ARIZONA DEPARTMENT OF VETERANS' SERVICES (ADVS)

PHYSICIAN'S STATEMENT IN SUPPORT OF TITLE 14
GUARDIANSHIP AND/OR CONSERVATORSHIP

PATIENT'S NAME: _____

I, _____, the personal physician of the above-named patient, submit this report to ADVS supporting my opinion of the need for appointment of a **GUARDIAN** and/or **CONSERVATOR**. I have been the patient's physician since _____ and saw this patient most recently on _____.

1. I am a licensed physician and am authorized to make this statement. My area of specialty is _____. I □ am □ am not Board Certified in this area. I am also Board Certified in the following area(s). _____
_____

2. I examined the patient on _____ in connection with the preparation of this report. I was asked to perform this evaluation because (please check all that apply) □ I have been the person's physician for many years, □ I was asked by the person's family, □ An attorney selected me, □ My office is close to the person's residence, □ I am the doctor for the person's nursing home, □ Other (please explain). _____
_____
_____

3. The patient has difficulty in the following area(s): □ mental illness or disorder; □ physical illness; □ chronic intoxication or drug abuse; □ cognitive abilities; □ other. Check all that apply and explain.
_____
_____
_____

4. The patient's primary diagnosis supporting a guardianship and/or conservatorship petition is _____. The patient has been suffering from this condition since _____ and □ has □ has not previously been treated or hospitalized for this condition.

5. The patient is limited in the following abilities due to his/her condition: □ to pay bills; □ to obtain food; □ to provide adequate housing; □ to perform daily self-help skills; □ to live alone; □ to take medication appropriately; □ to drive a motor vehicle (see #6 below) □ to make appropriate judgments that will protect the patient personally, physically, or financially.

6. If you believe the person is still able to drive a motor vehicle, but is in need of the assistance of a **GUARDIAN**, please explain why the person should be allowed to keep driving.
_____
_____
_____

7. The medications for which the patient is presently prescribed are: _____
_____
_____

8. I □ do □ do not believe the medication is affecting the patient's ability to respond coherently.

9. I □ do □ do not believe the medication is affecting the patient's ability to ambulate.

10. I □ do □ do not believe a "medication holiday," if possible, would help better evaluate this patient.

11. I □ do □ do not believe any changes made in the type or amount of drugs the patient is receiving would noticeably affect their mental or physical abilities.

12. I □ do □ do not believe further medical evaluation or treatment would benefit the patient. Explain. _____

13. I □ do □ do not believe the patient would benefit from other types of therapy such as counseling. Explain. _____

14. It is my belief the patient should be living: □ at home with a companion; □ at home with a nurse; □ in a group home; □ in a boarding home; □ in a supervisory care facility; □ in a nursing home; □ in a hospital; □ in a level one behavioral health facility for inpatient mental health treatment (if checked, complete page 3 of 3); □ other (please explain). _____

15. Based on the patient's condition described above, it is my opinion the patient is **GRAVELY DISABLED** and requires the **EMERGENCY** appointment of a **TEMPORARY GUARDIAN**: □ **YES** □ **NO**

16. Based on the patient's condition described above, it is my opinion the patient requires the appointment of a **GUARDIAN** as the patient is unable to make and communicate responsible decisions concerning his/her person: □ **YES** □ **NO**

17. Because of the patient's condition described above, it is my opinion the patient requires the appointment of a **CONSERVATOR** as the patient is unable to manage his/her property and affairs effectively, which property is needed for his/her care, support, and welfare: □ **YES** □ **NO**

18. I □ do □ do not believe that the patient's condition will improve within six months to a year.

19. I □ do □ do not believe that this matter should be reviewed by the Court within six months to one year.

20. Following are additional comments or suggestions I think would be helpful to the Court in making its decision. _____

Dated: _____

_____
Signature of Physician

_____
Physician's Printed Name (please attach business card)

Mental Health Treatment Issues (This page must be completed when requesting authority to consent to inpatient mental health treatment. Refer to question 14 on page 2 of 3)

1. Is it opinion of the undersigned the patient is incapacitated as a result of a mental disorder? □ **YES** □ **NO**

2. What is the mental disorder? _____

3. Is it the opinion of the undersigned that the patient is currently in need of inpatient mental health care and treatment? □ **YES** □ **NO** (For the purpose of this question, the term "currently" means, based upon the medical professional's experience and training, and to a degree of medical probability, the patient does now or will within a reasonably imminent and immediate time require inpatient mental health treatment.)

4. In the event the answer to #3 above is "Yes," please explain the need for, and the anticipated onset and duration of, the inpatient treatment. _____

5. What kind of treatment is the patient currently receiving for this disorder? _____

6. Give a comprehensive assessment of any functional impairments of the patient. _____

7. How, and to what extent, do these impairments affect the patient's ability to receive or evaluate information needed in making or communicating personal and financial decisions? _____

8. What task(s) of daily living is the patient capable of performing without direction or with minimal direction? _____

9. What is the most appropriate rehabilitation plan or care plan for the patient? _____

10. What would be the least restrictive living arrangement reasonably available for the patient? _____

11. Is there any reason why this patient should not personally appear in court? □ **YES** □ **NO** If "yes," please explain. _____

12. Please make any additional comments or suggestions you feel would be valuable to the court. _____

Dated: _____

_____
Signature of Physician

_____
Physician's Printed Name (please include business card)